

---

## Physician manpower requirements committee reports its progress

---

By J.B. Ralph McKendry, MD and N. Tait McPhedran, MD

How many physicians in each discipline are needed in Canada now and during the first half of the 1980s? While reasoned answers to this question are not readily obtainable, they must be sought because they are of such vital concern not only to physicians and medical educators but also to the public and to government agencies with administrative and fiscal responsibilities for effectiveness and efficiency in the health care system.

In 1972 the national physician manpower committee, which includes representatives from 10 national medical organizations and the Department of National Health and Welfare, adopted a proposal put forward by Dr. W. S. Hacon, director general of health manpower, DNH&W, to establish a subcommittee on physician manpower requirements which will "develop criteria and make recommendations regarding future requirements for physicians in the various disciplines in Canada".

The national committee enunciated guidelines for this requirements committee and these included selecting appropriate study projects, creating working parties composed of members of the 32 recognized medical specialties and general practice, utilizing effectively the available resource personnel and identifying sources of basic information to assist the working parties. Also the requirements committee would prepare a short guidance manual for working parties, suggest methods for analysis of data, help identify factors likely to influence present and future needs, and finally, collate, coordinate and evaluate the findings and recommendations of the working parties in the form of a report to the national committee.

By spring 1973 the CMA had appointed Drs. Claude Lauriault and N. Tait McPhedran; the RCP&S, Dr. J. B. R. McKendry; ACMC, Dr. F. G. Inglis; CFPC, Dr. A. T. Hunter; and DNH&W, Dr. Claude J. Delisle to

serve as members of the requirements committee.

Dr. McKendry was elected chairman; Dr. McPhedran, cochairman, and a secretariat under Dr. Delisle was established in the federal health manpower directorate.

A task force in the federal health department headed by Dr. R. A. Armstrong, director general, health insurance, was created to provide medical care utilization data for the requirements committee and the various working parties.

The requirements committee isolated its assignment into three overlapping phases:

- Immerse its members in manpower lore; develop policy, modus operandi and work schedules; develop methodology; establish liaison with technical advisers and assistants; prepare a manual for guidance of working parties.

- Arrange for representative national medical organizations and associations to appoint members to their respective specialty working parties; organize a series of meetings with, and by, working parties, briefing them, coordinating their contacts with resource persons of the task force and ensuring that working parties have adequate data to assist them in reaching reasonably firm and realistic estimates of physician requirements.

- Receive, assess, edit and collate the reports from some 30 working parties representing 33 disciplines; summarize and comment on these reports and produce a requirements committee report integrating the major conclusions and recommendations of the working parties. The full text of each working party report will be appended to that report.

The time-frame for completion of the assignment was tentatively set at 2 years. In approaching the task, the requirements committee assumed:

- That the objective was to ensure

an appropriate level of physician manpower to provide Canadians with a reasonably good quality of care and health surveillance.

- That for the next decade, physicians would continue to be involved principally with diagnosis and treatment of illness and injury.

- That all medical services rendered in the base year(s), for which medical care utilization data were available, were necessary, or at least that the deficit of unrendered necessary services approximated the unnecessary services rendered.

- That no large areas of unmet need exist because the perceived need for physicians' services approximates demand in a system which boasts universal prepaid insurance and one of the highest physician-to-population ratios in the world. (The Pickering report in Ontario, reports by P. E. Enterline, J. C. McDonald *et al* in Québec and other surveys reflect a public which is generally satisfied with current medical services.)

The nationwide demand for physician services should therefore be reflected in medicare utilization data — a record of all services for which benefits were claimed from provincial medical care insurance plans.

The requirements committee recommended that working parties primarily exploit to the fullest extent feasible these hard data. In Canada universal prepaid coverage and claims based on fees for designated services combine uniquely to provide these data. Dr. Armstrong was first to appreciate their potential application to help rationalize physician manpower planning.

The requirements committee with the assistance of the departmental task force evolved a methodology which was eventually tagged the physician workload approach. The working parties were invited to employ it insofar as it reflected the fee-for-service work performed by their specialty in the

British doctors are far from happy with the news that their traditional haven — Canada — may soon be closing its doors to them.

This was made clear by chairman of the British Hospital Doctors Association, Dr. Eleanor Kapp. She speaks for a section of the British medical profession which is currently feeling restless over threats to make the National Health Service an all-embracing state monopoly.

Secretary of State for Health Barbara Castle has introduced new contract proposals for NHS hospital doctors; these are viewed by many as a state takeover or at least a serious erosion of fundamental medical freedom.

Dr. Kapp said: "Many British doctors look upon Canada as one of the best countries in the world in which to practise medicine. They recognize that health care delivery is well-organized there and that members of the medical profession have managed to retain the respect of the community.

"We have been unhappy about the state of medicine in Britain for some years and Canada has been regarded as a kind of haven to which there would always be an escape.

"With the current difficulties we are facing, an increasing number of junior hospital doctors feel they need

an escape from the unsatisfactory state of affairs they find at home. While we quite understand Canada's reasons for wanting to restrict the flow of incoming medical graduates, we hope that, if there is to be a quota, the Canadian authorities will still look favourably upon doctors trained in Britain."

This view was endorsed by Dr. Norman Simmons, an executive member of the Hospital Consultants and Specialists Association. The association has been growing rapidly in the last year and is now in the forefront of protests against Mrs. Castle — notably in the organizing of the senior doctors' work-to-contract which is the profession's practical demonstration of its objections to Mrs. Castle's plans.

Dr. Simmons said: "I suspect the news that Canada is closing her doors will create a great rush of senior doctors who will try to get in before the chop comes. Many, of course, will be disappointed. The Hospital Consultants and Specialists Association is, however, mainly concerned with conditions in the United Kingdom. We quite understand how the Canadians feel because we too have problems with the importation of overseas-trained doctors. Canada stands highest on the list of places to which British doctors would like

to emigrate, so any restrictions on these movements will be a blow to them. In Canada they (British doctors) have been able to make an easy social transition, speaking their own tongue and practising medicine as they would like to see it practised at home."

A spokesman for the British Medical Association commented that while the news of possible restricted emigration to Canada would disappoint many British doctors, they at least had the prospect of soon being able to transfer to Europe.

Under the rules of the European Economic Community, professionals are expected to have freedom of access to member countries. Negotiations to achieve this freedom are well ahead and are expected to be completed by the end of this summer.

The spokesman said it was expected that British doctors would be able to practise in Europe from the beginning of 1976 and many were already looking towards the EEC for a possible continuation of their careers.

Salaries for doctors in most European countries were considerably better than in UK and most centres were near enough to Britain to allow occasional trips home.

A.M.

base year(s). Other approaches were not excluded, and, indeed, it was recognized that some specialties with a relatively small proportion of fee-for-service work would need the Delphi approach.

In the physician workload approach the general procedure was first to determine from medical care insurance data the volume and types of fee-for-service work performed by each specialty during the base year(s). To best compare data from different provinces, this approach grouped items of the individual fee schedules into 120 type-of-service categories and further categorized them into 14 broader type-of-service groupings: consultations, complete examinations, other office visits, home visits, major surgery, minor surgery, surgical assistance, obstetric services, anesthesia, diagnostic radiology, laboratory services, other diagnostic/therapeutic services, other hospital visits and miscellaneous services.

Next, the specialty working parties were asked during initial meetings to indicate the average working time (in minutes) for each generic type-of-service category. In specialties such as surgery, obstetrics and anesthesia, working times were assigned individually to the commoner procedures. Times for both direct patient contact and indirect contact were assigned by consensus of

working party members (and in many cases were also based on questionnaire surveys of substantial segments of a specialty). Thereby the volume of each category could be converted to patient-related working times.

Each working party was asked to define its specialty, indicate the optimum proportion of referral-only work, determine the length of an optimum physician work-week in hours and work-year in weeks, list procedures or activities exclusively claimed and those shared with other specialties (naming those other specialties), indicate whether the total volume of work rendered by its specialty in the base year(s) was appropriate and describe the impact on physician manpower requirements in its specialty from a variety of trends — such as demographic, socioeconomic, payment mechanisms, treatment and technology, methods for delivery of care, training, professional attitudes, public attitudes.

The working parties were also asked for an indication of average waiting-time for an appointment for nonurgent conditions in various regions, an estimate of percentage change required to render manpower supply optimum in the discipline, views on how best to adjust for physician manpower and an opinion as to whether the output of newly trained physicians from resid-

ency programs in various regions was adequate, excessive or appropriate.

Since the workload approach based on utilization data alone would fail to reflect other than fee-for-service activities, working parties were asked to estimate requirements for administrators, teachers and researchers based on the needs of a population module of 500 000. This size was selected because the physician manpower requirements to serve such a population and area should reflect all types of primary, secondary and tertiary care as well as research and teaching facilities in some known instances. Application of this concept of a half-million module was also advocated as the basis for estimating the remaining physician workload not visible in medical care utilization data, that is, for physicians employed in industry, government and other institutions. It was also recommended when considering needs for certain subspecialists or for other *rarae aves*.

Currently, the requirements committee's activities are approaching the end of its second phase. By the end of this month all working parties should have submitted their reports. The requirements committee has set itself a fairly ambitious deadline of May 15, 1975 for completion of its report to its parent committee, the national committee on physician manpower. ■